## CITY OF IDAHO FALLS EMPLOYEE FITNESS & RECREATIONAL BENEFITS PROGRAM MEMBERSHIP APPLICATION

Seasonal



	EMPLO' FORMA		
Name:			
Date of Birth:			
Vork Phone:		Cell Phone:	
Email:			
Current Address:			
City:	State	<u>:</u>	ZIP Code:
Department of Employment:			
Position:	How	How long?	
E	MERGE CONTA		
Name:			
Address:		Phone:	
City:	State	) <b>:</b>	ZIP Code:
Relationship to Employee:			
AUTHORIZ TREATMEN	_	_	
I hereby authorize and give my consent to the City physician to perform upon or administer any reas necessary in their best judgment to stabilize my necessary medical treatment as so authorized and any obligation or responsibility with respect the disability or other limitation that would pose any por I further represent that I have no allergy to any medication, exceptions.	sonable and i condition or to hold harm reto. I furthe otential risk conedication or	necessary medica to preserve life on thess and release the er represent that of bodily harm or it	, surgical or emergency treatment as ir limb. I further agree to pay for all the City and its' officers or agents from I have no condition, illness, disease, injury to me, except as disclosed above. imiting the administration of drugs or
I further agree to indemnify and hold harmless any of actions, suits, injury claims, or demands asserte unlawful conduct by me during t	ed by any thi	rd party, with res	pect to any act, omission, wrongful or
This Agreement shall be binding upon the heirs, po	ersonal repre	esentatives, succe	
Signature of Employee:			Date:
Regular/PERSI		SE ONLY Official HR R	Representative:

## CITY OF IDAHO FALLS EMPLOYEE FITNESS & RECREATIONAL BENEFITS PROGRAM MEMBERSHIP APPLICATION



EMPLOYEE INFORMATION					
Name:					
Date of Birth:					
Work Phone:	Cell Phone:				
Email:					
Current Address:					
City:	State: ZIP Code:				
Department of Employment:					
Position:	How long?				
EMERGENCY CONTACT					
Name:					
Address:	Phone:				
City:	State: ZIP Code:				
Relationship to Employee:					
AUTHORIZATION FOR MEDICAL TREATMENT/INDEMNIFICATION					
I hereby authorize and give my consent to the City of Idaho Falls and its officers, agents and employees and any licensed physician to perform upon or administer any reasonable and necessary medical, surgical or emergency treatment as necessary in their best judgment to stabilize my condition or to preserve life or limb. I further agree to pay for all necessary medical treatment as so authorized and to hold harmless and release the City and its' officers or agents from any obligation or responsibility with respect thereto. I further represent that I have no condition, illness, disease, disability or other limitation that would pose any potential risk of bodily harm or injury to me, except as disclosed above. I further represent that I have no allergy to any medication or other condition limiting the administration of drugs or medication, except as otherwise disclosed above.  I further agree to indemnify and hold harmless any officer, agent or employee of the City from any and all actions, causes of actions, suits, injury claims, or demands asserted by any third party, with respect to any act, omission, wrongful or unlawful conduct by me during the course of my participation in program/activity.  This Agreement shall be binding upon the heirs, personal representatives, successors, and assigns of the undersigned.					
Signature of Employee:	Date:				
Regular/PERSI Initial of Official HR Representative:  Seasonal					